TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name
STEVEN W MICHELSEN DO

MFDR Tracking Number
M4-17-3317-01

MFDR Date Received
July 14, 2017

Respondent Name
ALLMERICA FINANCIAL BENEFIT INSURANCE

Carrier's Austin Representative
Box Number 01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the corrected claim providing the Physical Therapist name, Ashis Patel DPT, along with their license number... in box 31 of claim form."

Amount in Dispute: $1,540.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Corvel respectfully notes the health care provider's original submission of billing contained Steven W. Michelson, DO in field 31 as the physician that rendered services with his NPI listed in 24j. A corrected claim was submitted...with Ashis Patel, DPT in field 31. However, the information listed in field 24j continues to reflect Steven W. Michelson as the rendered in provider."

Response Submitted by: CORVEL

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
August 22, 2016 through August 31, 2016	97110 x 4 and 97140 x 4	$1,540.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the guidelines for Medical Bill Submission by Health Care Provider.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B20 – Srvc partially/fully furnished by another provider
   - 219 – Based on extent of injury
   - Note: Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the healthcare or that provided direct supervision of an unlicensed individual who provided the health care

Issues

1. Do dates of service August 25, 2016, August 29, 2016, and August 31, 2016 contain unresolved CEL issues?
2. Did the requestor submit documentation according to 28 Texas Administrative Code §133.20?
3. Is the requestor entitled to reimbursement for date of service August 22, 2016?

Findings

1. The requestor seeks reimbursement for dates of service August 25, 2016, August 29, 2016, and August 31, 2016. The insurance carrier in the position summary states in pertinent part, "To date there is no evidence that the extent of injury issue has been resolved. (See attached PLN-11)."

   28 Texas Administrative Code §133.305(b) states that if a dispute regarding extent of injury exists for the same service for which there is a medical fee dispute, the dispute regarding extent of injury shall be resolved prior to the submission of a medical fee dispute.

   Documentation provided by the parties indicates that the insurance carrier denied payment to the requestor due to an unresolved extent of injury issue. The carrier's explanation of benefits was timely presented to the requestor in the manner required by 28 Texas Administrative Code §133.240.

   The Division finds that dates of service August 25, 2016, August 29, 2016, and August 31, 2016 contain an unresolved extent of injury issue. For that reason, this matter is not eligible for adjudication of a medical fee under 28 Texas Administrative Code §133.307.

   The Division hereby notifies the requestor that the appropriate process to resolve the extent of injury issue is found a Texas Labor Code, Chapter 410, and corresponding 28 Texas Administrative Code §141.1. The requestor may choose to file the required DWC Form-045 titled *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC)* to resolve this matter. A copy of the form and corresponding instructions are attached.

2. The requestor seeks reimbursement for CPT Codes 97110 and 97140 rendered on August 22, 2016. The insurance carrier denied/reduced the disputed service with denial reduction code "B20 – Srvc partially/fully furnished by another provider" and "Note: Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the healthcare or that provided direct supervision of an unlicensed individual who provided the health care."

   28 Texas Administrative Code §133.20 states in pertinent part, "(e) A medical bill must be submitted... (2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

   Review of the CMS-1500, box 31 which requires the signature of physician or supplier including degrees or credentials, contains the name Ashis Patel DPT along with their license number. Review of the CMS-1500, box 24j, contains the NPI number for Steven W. Michelsen, DO. Review of the medical documentation dated August 22, 2016 identifies the provider of service as Steven W. Michelsen, DO. The Division finds that the requestor submitted insufficient documentation to support that the requirements of 28 Texas Administrative Code §133.20 were met. As a result reimbursement for the disputed date of service August 22, 2016 cannot be recommended.

3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for date of service August 22, 2016. As a result, $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 27, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**. A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).